

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

02824

181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Harford
 County: Aberdeen
 City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years.
 Hospital, institution, or street address where death occurred: Osborne Avenue, Aberdeen, Md.
 How long in hospital or institution? home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Harford
 City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Osborne Road (If rural, give LOCATION)
 2.(a) II veteran, name war: None

3. (a) FULL NAME Mary Ann Dolan Baswell

3. (b) Social Security Number None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Lonnie A. Baswell
 7. Birth date of deceased (mo., day, yr.) January 30, 1905 6.(c) If alive, give age _____ years
 8. AGE: 43 Years 1 Months 49 Days 9 hrs. 20 min. 11 less than one day
 9. Birthplace Baltimore City, Md. (Town, county, and state)
 10. Usual occupation housewife.

11. Industry or business none
 MOTHER FATHER
 12. Name John Francis Dolan
 13. Birthplace Baltimore, Maryland
 14. Maiden name Mary Margaret Roth
 15. Birthplace Baltimore City, Md.
 16. Informant Mary Roth Price
 Address Aberdeen, Md.

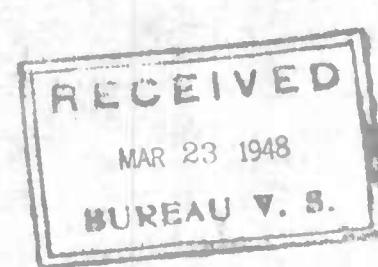
17. burial. Date thereof Mar. 22-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

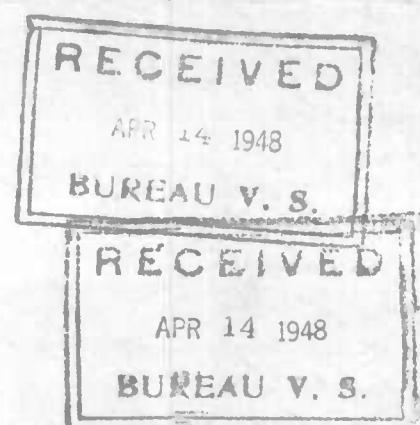
Cemetery or crematory Secret Heart of Jesus
 Location Baltimore Md.
 18. Funeral director Henry James Jones
 Address Aberdeen Md.

19. Mar. 20 1948 Nellie H. Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 20
 20. DATE OF DEATH March 19 1948 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1948 to March 19 1948, and that I last saw her alive on March 13 1948.
 Immediate cause of death hypostatic pneumonia DURATION 5 days
 Due to paraplegia of legs 12 years
 Due to spine injury 1936 12 years
 Other conditions idiopathic 30 years
 epilepsy (Include pregnancy within 8 months of death)
 Major findings of operations none Date of op. none

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of _____ Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Aubrey V. Gould Jr. M.D. M. D. or other
 Address Haute de Grâce, Md. Date signed 3/19/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH*

2411 N. Charles St., Baltimore

462

02826

781

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: HarfordCounty: RuralCity or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Eugene Billingslea4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Emma C. Bodt7. Birth date of deceased (mo., day, yr.) November 7th 18776. (c) If alive, give age 66 years8. AGE: 70 Tears 4 Months Days If less than one day

hrs. min.

9. Birthplace Calvary Harford Co. Md

(Town, county, and state)

10. Usual occupation Corn Canner, Ptd.11. Industry or business Charlie B. Billingslea12. Name Charlie B. Billingslea13. Birthplace Calvary Harford Co. Md14. Maiden name Virginia McGonnigall15. Birthplace Churcherville Harford Co. Md16. Informant Mrs. Eugene BillingsleaAddress Aberdeen, Md. P. O. D.17. Burial Cemetery or crematory Smiths ChapelDate thereof Male 14 1948(Burial, cremation, or removal. Which?) (month) (day) (year)Location Churcherville, Md18. Funeral director Henry Tanning & SonsAddress Aberdeen, Md19. Date rec'd by registrar Mar. 13 1948(Date rec'd by registrar) Nellie N. RileyRegistration No. 462

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MarylandCounty: HarfordCity or town: Rural - Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Churcherville

(If rural, give LOCATION)

2.(a) If veteran, name war: None3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th 1948 at 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1946 to Mar 11 1948and that last saw him alive on Mar 11 1948

Immediate cause of death:

Carcinoma sigmoidor RectumDue to: Carcinomatous

Due to:

CachexiaOther conditions: Cachexia

(Include pregnancy within 3 months of death)

Major findings of operations: as above Date of op. 8/1945Autopsy results: 11/18/47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

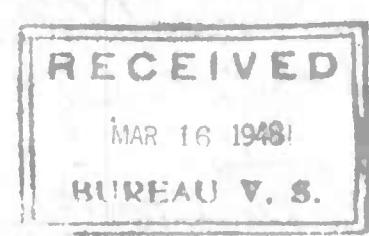
Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Charles J. Foley M.D. or otherAddress: 1111 Old Main St. Aberdeen, Md Date signed: Mar 13 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

946

02827

181

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Aberdeen

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred

17 Liberty St.

How long in hospital or institution?

3. (a) FULL NAME

Louis SAVATORE BONGIOVANNI

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Valentino Scaroni

7. Birth date of deceased (mo. day, yr.)

April 21st 1882

6. (c) If alive, give age 57 years

8. AGE:

Years 65 Months 11 Days

If less than one day hrs. min.

9. Birthplace

Italy (Town, County, and state)

10. Usual occupation

Contractor

11. Industry or business

Nicholas Bongiovanni

12. Name

Nicholas Bongiovanni

13. Birthplace

Italy

14. Maiden name

Unknown

15. Birthplace

Italy

16. Informant

N. J. Bonge

Address

87 Liberty St. Aberdeen, Md.

17. Removal

Date thereof: May 30, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Calvert

Location

Buffalo, N. Y.

18. Funeral director

Henry Tarrin & Sons

Address

Aberdeen, Md.

19. Date rec'd by registrar

Mar. 30 1948

(Date rec'd by registrar)

Nellie H. Riley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

New York County

Buffalo

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1113 1/2 Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 29 1948 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

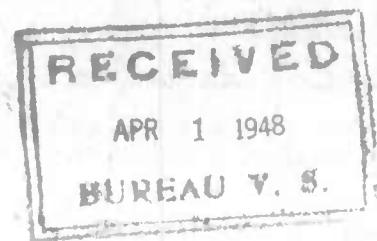
23. SIGNATURE

John H. Riley, M.D.

Aberdeen, Md.

Date signed

3/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02828

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County

Harford

City or town

HAURE de GRACE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs.

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Mr. Norval Carr

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Agnes C. Carr

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1891

8. AGE:

Years
56Months
10Days
6If less than one day
hrs. min.

9. Birthplace

Harford Co. (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Atha Carr

13. Birthplace

Harford Co.

14. Maiden name

Sarah

15. Birthplace

?

16. Informant

Agnes C. Carr (wife)

Address

428 S. Washington St.

17. Burial

Date thereof 3/11/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Angel Hill

Location

Haure de Grace

18. Funeral director

Pennington & Son

Address

Haure de Grace

19. May. 10 1948

(Date rec'd by registrar)

G. L. Lewis M. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Harford

City or town

Haure de Grace

Street No.

428 S. Washington St.

(If rural, give location)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 the 1948 at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 8, 1948 19 to same 19.

and that I last saw him alive on same 19.

Immediate cause of death

Acute coronary occlusion

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Nogueira M.D. M. D. or other

Address Haure de Grace Date signed 3. 8. 48

RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If ~~incorrect age~~ is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02829

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County

City or town

Harford
street

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Caroline Williamson Collier

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Frank A. Collier

7. Birth date of deceased (mo., day, yr.)

Dec 12, 1878

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69

3

hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Charles H. Keite

12. Name

Philadelphia, Pa.

13. Birthplace

Eleanor Williamson

14. Maiden name

Philadelphia, Pa.

15. Birthplace

Mrs. David Slade

16. Informant

Street, Md.

Address

Burial

Date thereof: Nov. 17, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mount Rose Cemetery

17. Location

Highland Park, Pa.

Funeral Director

Burke & Sons

Address

Brentwood, Md.

18. Funeral Director

Thomas R. Brown

Address

May 16, 1948

(Date rec'd by register)

19. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Harford

City or town

Harford Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1948, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19, 1948, to March 12, 1948,

and that I last saw her alive on March 12, 1948.

Immediate cause of death: General

Hemorrhage.

DURATION

1wks.

Duo to: Hypertensive cardio

vascular disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles C. Jeff, M.D.

Address: Street, Md. Date signed: May 13, 1948

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02830

151

CERTIFICATE OF DEATH

Reg. Diat. No.

185-

1. PLACE OF DEATH:

County

City or town

Harford
Hause de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital institution, or street address where death occurred:

Harford General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Baby Girl Du Pree (Dora Blaine)

3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

newborn infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 29 - 48

6. (c) If alive, give age years

8. AGE: Years

0

Months

0

Days

4

If less than one day

hrs.

min.

9. Birthplace

Harford de Grace - Harford - Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Joseph Du Pree

Maryland

13. Birthplace

Jessie Patterson

Ga.

14. Maiden name

15. Birthplace

16. Informant

Joseph Du Pree

Address

Perryville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Port Deposit, Md R.D.

18. Funeral director

Lee O. Patterson & Son

Address

Perryville, Md.

19. Date rec'd by registrar

Mar. 5

1848

(Date rec'd by registrar)

Date thereof

Mar. 5

(month) (day) (year)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Cecil

City or town

Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4th 48 1948 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to

to

and that I last saw h. alive on

Immediate cause of death

Cystic respiratory failure
Prematurity

DURATION

Due to

Due to

Other conditions Hemolytic disease of the newborn
(Mother had hydranmios)

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

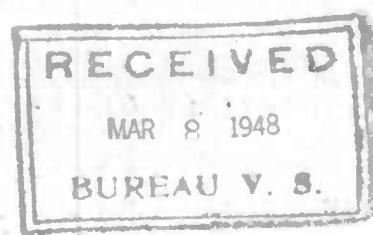
Injured at work?

23. SIGNATURE

M. D. or other

John F. Noguera MD.

Hospital - Hause de Grace Date signed 3.4.48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02831

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County HARFORD

City or town EDGEWOOD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 1/2 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

MARY ANN EDWARDS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white widowed

6.(b) Name of husband or wife

Thomas R. Edwards

7. Birth date of

deceased (mo. day, yr.)

Feb 12, 1869

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day
79 1 3

hrs. min.

9. Birthplace

(Town, county, and state)

Mahanoy City, Pa

10. Usual occupation

Housewife

11. Industry or business

12. Name Llewellyn Reddow

13. Birthplace Wales

14. Maiden name Anna Jenkins

15. Birthplace Wales

16. Informant Mrs. Ralph Lehe

Address 29 Armstrong St, Edgewood Md

17. Transportation Date thereof Mar 15, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Pitt Funeral Home

Location Mahanoy City, Pennsylvania

18. Funeral director Howard C. McCorison

Address Abingdon Maryland

19. Mar 17 1948 Name M. M. Mouldale

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Maryland County Harford

City or town Edgewood (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1948 21 100 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/13 1948 10 3/15 1948

and that I last saw h. F. R. alive on 3/13 1948

Immediate cause of death PROBABLE CORONARY

OCCLUSION DURATION 2. DAYS

Due to ARTERIOSCLEROSIS

Due to Other conditions NONE EXCEPT DIFFUSE

M.Y.O.CARDI.D.L. D.A.M.A.G.E.

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. —

Autopsy results NOT DONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; —

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

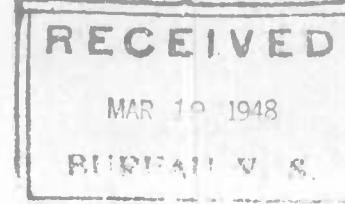
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE C. W. Stewart, Jr., M.D.

M. D. or other

Address 126 YAHDE ST. E. EDGEWOOD, MD Date signed 3/15/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02832

CERTIFICATE OF DEATH

114e

181

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 days

Hospital, institution, or street address where death occurred:

Bks 158 Ord Sch Aberdeen Proving Ground, Md.

How long in hospital or institution?

3. (a) FULL NAME

EMES, GEORGE F.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

February 18, 1918

8. AGE:

Years Months Days If less than one day
30 0 16 hrs. min.

9. Birthplace Johnstown, Pennsylvania

(Town, county, and state)

10. Usual occupation Soldier

11. Industry or business U. S. Army

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Personnel Section Ordnance School

Address Aberdeen Proving Ground, Maryland

17. (Burial, cremation, or removal. Which?) Cremation

Date thereof Mar 4, 1948
(month) (day) (year)

Cemetery or crematory Temple Funeral Home

Location Petersburg, Pennsylvania

18. Funeral director Howard T. McCombs & Son

Address Abingdon Maryland

19. Mar 8, 1948
(Date rec'd by registrar) Nellie E. Riley
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania

County Huntingdon

City or town Alexander

(If outside city or town limits, write RURAL and give nearest town)

Street No. General Delivery

(If rural, give LOCATION)

2. (a) If veteran, name war World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

March 3 1948 at 9:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

19.

and that I last saw h. alive on Dead on arrival

19.

Immediate cause of death U.S.A. 14/27/48

DURATION

(pending analysis of laboratory)

Due to From available evidence, a definite cause of death cannot be established

Due to 14/27/48

Other conditions At 10:15 A.M. bilateral

parted

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

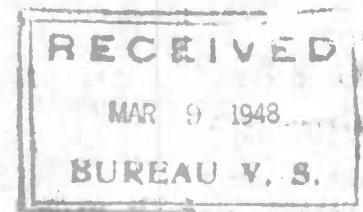
Means of injury

Injured at work?

23. SIGNATURE

Helen Riley, Death Dept. of Dept. of Health
Aberdeen Proving Ground, Maryland Date signed Mar. 3, 1948

no bgnit null



Evidence for change of age
and birth date shown on: MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02833

ALM NO. G 114 MAR 30 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 163

1. PLACE OF DEATH:

County.....

City or town.....

Hanford

Forest Hill (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martha Jannie Eppes

4. Sex

Female

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Joseline Eppes

6. (c) If alive, give age..... 39 years

7. Birth date of
deceased (mo., day, yr.)

May 9 1909 1910

8. AGE:

Years 37

Months 8

Days 10

If less than one day 4

hrs. min.

9. Birthplace

Richmond Va

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

12. Name

Charles Booker

13. Birthplace

Va

14. Maiden name

Mary W Eggleston

15. Birthplace

Va

16. Informant

Joshua Eppes

Address

Forest Hill Md

17. Burial

Date thereof March 17 48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Keysville

Location

Va

18. Funeral director

Katie R Williams

Address

322 N. Schubert St Baltimore

19. Date rec'd by registrar

May 16 1948 Thomas R Brown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Hanford

City or town

Forest Hill (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 13 1948 1/2

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

and that I last saw h..... alive on

Immediate cause of death

Fracture cervical
vertebra

DURATION

incident

Due to

Due to

Other conditions

Fracture skull
compound & comminuted

1.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

Where did injury occur?

Forest Hill

(City or town)

(County)

(State)

Farm

Injured at home, farm, industry, public place (where?)

Means of injury

Tractor

Injured at work?

Yes

Harold C Palmer

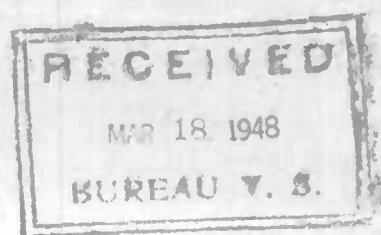
Family Physician Medical Examiner

M. D. or other

Address

Baltimore County

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02834

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:
 County Harford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida May Gaunt

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles B. Gaunt

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1869 6. (c) If alive, give age _____ years

8. AGE: Years 78 Months 4 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Edgewood, Harford Co., Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Whittier

MOTHER FATHER 12. Name Charles B. Gaunt

13. Birthplace Edgewood, Maryland

14. Maiden name unknown

15. Birthplace Edgewood, Maryland

16. Informant Charles B. Gaunt

Address Edgewood, Maryland

Burial Burial

Cemetery or crematory Brookbury

Location Abingdon, Maryland

18. Funeral director Howard W. McCormack

Address Abingdon, Maryland

19. Date rec'd by registrar Mar 21 1945

Registrar Wm. W. Mouldale

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Harford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 19, 1948 at 12:59 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1945 to March 19, 1948
 and that I last saw her alive on March 18, 1948

Immediate cause of death

Acute Pulmonary Disease - 2 hrs

Due to

atherosclerotic CV Disease 6 yrs

Other conditions Arteriosclerotic Hypertension 6 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

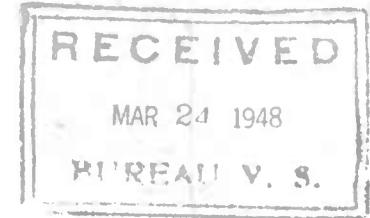
Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

I. Ralph Herkamp M.D. or other
 Address Charlottesville, Va. Date signed March 19



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02835

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County

Harford

City or town

Hause de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Hause de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

125 S. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Miss Rose Green

3.(b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 29th 48

19

at 1/10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 1948 to March 29 1948

and that I last saw her alive on March 29-48

19

Immediate cause of death

Hypertensive cardiovascular

disease

DURATION

Due to: a Congestive heart

failure and

?

Due to: Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

John F. Noguera MD

(Date signed) 3-29-48

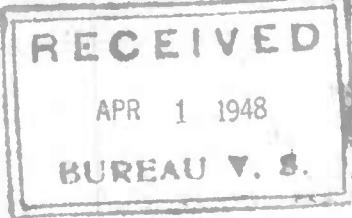
Address: Hospital Hause de Grace

Mar. 30 1948

(Date rec'd by registrar)

G. L. Lewis, M.D.

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02836

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County

City or town

Harford

Garrettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jane Hall

4. Sex

F.

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Joshua Hall

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Jan. 3, 1851

8. AGE:

Years

Months

Days

If less than one day

27

hrs.

min.

9. Birthplace

(Town, county, and state)

Garrettsville

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Lairson Franchise

MOTHER FATHER

not known

MOTHER FATHER

Charity

MOTHER FATHER

not known

MOTHER FATHER

Stanley Glover

MOTHER FATHER

Forest Hill, Md

MOTHER FATHER

Burial

MOTHER FATHER

Fairview

MOTHER FATHER

Forest Hill, Md

MOTHER FATHER

Martin G. Kury

MOTHER FATHER

Garrettsville, Md.

MOTHER FATHER

Address

MOTHER FATHER

Mar. 4, 1948 Thomas P. Brown

MOTHER FATHER

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Garrettsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2, 1948, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 24, 1948, to Mar. 2, 1948

and that I last saw her alive on Mar. 1, 1948

Immediate cause of death

Chr. Cardio-Vascular Disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

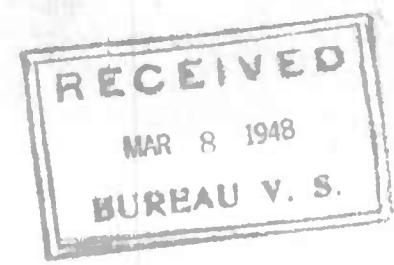
Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson M.D. M.D. or other

Address Forest Hill, Md. Date signed 3/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02837

468

CERTIFICATE OF DEATH

186-

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford
City or town St. Anne de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days in hosp.Hospital, institution, or street address where death occurred: Harford Memorial HospitalHow long in hospital or institution? 4 days

3. (a) FULL NAME

Harry J. Hess

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 15 1874

8. AGE:

Years 71Months 7Days 5

If less than one day

hrs. 0min. 0

9. Birthplace

(Town, county, and state)

Rutledge Maryland

10. Usual occupation

Sta. keeperSt. Anne de Grace

11. Industry or business

St. Anne de GraceIndie.

12. Name

Jacob Hess

13. Birthplace

Harford Co Md.Maryland

14. Maiden name

Mary PrestonMary Preston

15. Birthplace

Harford Co MdHarford Co Md

16. Informant

Milton HessMilton Hess

Address

Fallston MdFallston Md

17. Burial

Date thereof March 23 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Good WillGood Will

Location

Rutledge Harford Co MdRutledge Harford Co Md

18. Funeral director

Martin G. L. LewisMartin G. L. Lewis

Address

Janettsville MdJanettsville Md

19. Date rec'd by registrar

Mar. 21 1948A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Fallston (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-20-48 19 at 5:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-17 1948 to 3-20 1948and that I last saw him alive on 3-20 1948

Immediate cause of death

Carcinoma of the liver

Due to

Exhaustion - Anemia

Due to

Probably Cancerous & Infected

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

John J. Lewis M.D.

M. D. or other

Address St. Anne de Grace Date signed 3-21-48

RECEIVED

MAR 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02838

181

Reg. Dist. No.

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH: Harford
 County: Rural & Aberdeen
 City or town: Rural & Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About
 Hospital, institution, or street address where death occurred:
Belt Belair Ave., extended
 How long in hospital or institution?

3. (a) FULL NAME Jennie W. Holloway

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William E. Holloway

7. Birth date of deceased (mo., day, yr.) June 19, 1871 6. (c) If alive, give age years

8. AGE: Years 76 Months 10 Days 5 If less than one day
 hrs. min.

9. Birthplace Franklinville, Balto, Co., Md.
 (Town, county, and state)

10. Usual occupation At home

11. Industry or business John A. Burrier

MOTHER FATHER 12. Name John A. Burrier
 13. Birthplace Unknown

14. Maiden name Sarah W. White
 15. Birthplace Cecil Co., Md.

16. Informant Miss Heila Fosta

Address Aberdeen, Md. P.O.

17. Burial Burial Date thereof March 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cemetery Grove Presbyterian

Location Aberdeen, Md.

18. Funeral director Henry Tanning & Son

Address Aberdeen, Md.

19. Date rec'd by registrar May 25, 1948 Date signed Nellie F. Riley

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Harford
 City or town: Rural - Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Belair Ave., extended
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 11 1948 to March 24 1948

and that I last saw her alive on March 24 1948

Immediate cause of death

Pneumonia terminal duration terminal

Due to Inflammation & Dehydration 3 days duration 3 days

Due to Thrombosis of middle cerebral artery with emboli 6 weeks duration 6 weeks

Other conditions Arteriosclerosis 14 years duration 14 years

PREGNANT (Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op. Not done

Autopsy results Not done Date of op. Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

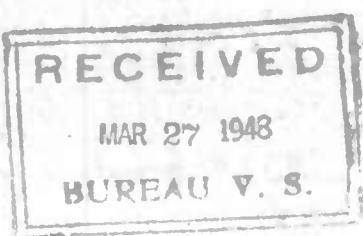
Where did injury occur? None (City or town) None (County) None (State) None

Injured at home, farm, industry, public place (where?) None

Manner of injury None Injured at work? None

23. SIGNATURE Nellie F. Riley M.D. or other None

Address Belair Ave., Aberdeen, Md. Date signed May 25, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02839

CERTIFICATE OF DEATH

Reg. Dist. No. 185-138

1. PLACE OF DEATH:

County

City or town

Harford
Haure de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 5 hours

3. (a) FULL NAME

Eugene
Mr. Malcolm Hummel Jr.

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ruth Haas Hummel

7. Birth date of deceased (mo., day, yr.)

6-18-17

8. (c) If alive, give age 30 years

8. AGE:

Years
30Months
9Days
10It less than one day
.....hrs.min.

9. Birthplace

Penn

(Town, county, and state)

10. Usual occupation

Cashier

11. Industry or business

First Natl. Bank

MOTHER FATHER

Malcolm E. Hummel Sr.

12. Name

Penn.

13. Birthplace

Penn.

14. Maiden name

Helen Feiner

15. Birthplace

Penn.

16. Informant

Mrs Ruth Haas Hummel

Address

618 Fountain St.

17. Burial

Union Cem.

(Burial, cremation, or removal. Which?)

Date thereof: Apr. 1st 1948
(month) (day) (year)

Cemetery or crematory

Sladerton, Penn.

Location

R. Madison Mitchell

18. Funeral director

Haure de Grace Md.

Address

Mar. 30 1948 G. L. Lewis M.D.

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Haure de Grace

Street No.

618 Fountain St.

2. (a) If veteran, name war

3. (b) Social Security Number

166-03-0300

MEDICAL CERTIFICATION

March 28 1948 at 205 M

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28 1948 to same 19

and that I last saw h m alive on same 19

Immediate cause of death

Pulmonary Tuberculosis

DURATION

?

Due to

Due to

Other conditions: Tuberculosis of kidney & bladder. - Secondary anemia

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address: John F. Nogueira MD

Hospital Haure de Grace

Date signed: 3-28-48

RECEIVED

APR 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02840

159

CERTIFICATE OF DEATH

Reg. Dist. No. 185

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Harford
 City or town Hause de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or Institution?

3. (a) FULL NAME Baby Boy Ingram, Willie Junior

4. Sex M. 5. Color or race C. 6. (a) Single, married, widowed, or divorced newborn infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.) Mar. 22-48 at 8 48 pm years

8. AGE: Years — Months — Days — If less than one day 5 hrs. 15 min.

9. Birthplace Hause de Grace, Harford Md.
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER Willie Miller

13. Birthplace Sumpter South Carolina

14. Maiden name Rolla Roads

15. Birthplace Greenwood Miss.

16. Informant Willie Miller

Address 514 Freedom St. Hause de Grace

17. Burial Burial Date thereof March 24 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. James Cemetery

Location Angle Hill

18. Funeral director Calmen E. Bullock

Address 656 Lewis St. Hause de Grace

19. Date rec'd by registrar Mar. 24 1948 A. L. Lewis M. D.
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Harford

City or town Hause de Grace
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 812 Lewis St.
 (If rural, give LOCATION)

2. (a) If veteran, name war ✓

3. (b) Social Security Number ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 a. 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 22-48 to Mar. 23 1948

and that I last saw him alive on Mar. 22-48

Immediate cause of death Central respiratory failure DURATION

Due to Prematurity

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

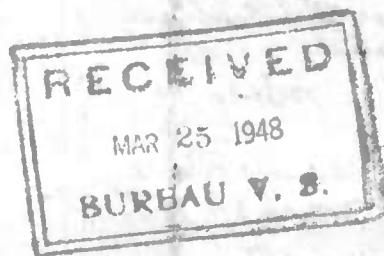
Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE John F. Noguera MD M. D. or other

Address Hause de Grace Md. Date signed 3/23/48



Evidence for change of
age and birth date
shown on!

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02841

93d

Reg. Dist. No. 185-

Film No. G 114 MAR 30 1948

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Harford

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hause De Grace Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Annie Jamison

4. Sex

F.

5. Color or race
C.

6. (a) Single, married widowed or divorced

6. (b) Name of husband or wife

John Jamison

6. (c) If alive, give age years

7. Birth date of
deceased (mo. day, yr.)

1862 - 1867

8. AGE: Years

Months Days If less than one day

81 8 2

hrs. min.

9. Birthplace

(Town, county, and state)

MD

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Nolan

13. Birthplace

not known

14. Maiden name

"

15. Birthplace

"

16. Informant

Mrs. Charles Walton

Address

Rock Harford Co Md

17. Burial

(Burial, cremation, or removal which?)

Date thereof (month) (day) (year)

Mar 18 1948

Cemetery or crematory

St. James (colored)

Location

Federal Hill

18. Funeral director

Charles E. Knott

Address

Garrisonville

19. (Date rec'd by registrar)

Mar 16 1948

A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Harford (Rural)

City or town

Racks

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 16th 1948 at 7 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 8. 48 to Mar 16. 48.

and that I last saw her alive on Mar 15. 48.

Immediate cause of death

Cerebral vascular accident

Due to Hypertensive cardiovascular disease

Due to

Other conditions Generalized arteriosclerosis

+ chronic myocarditis

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD

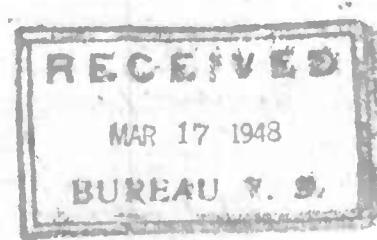
M. D. or other

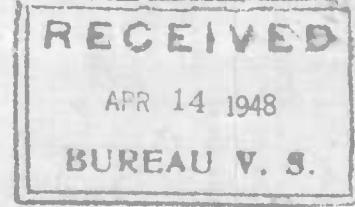
Hospital - H. de Grace Date signed 3/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The suspect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02843

CERTIFICATE OF DEATH

Reg. Dist. No... 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Harford
 County: Belle Air
 City or town: Belle Air (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, Institution, or street address where death occurred: LaPorte
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Harford County: LaPorte
 City or town: LaPorte (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)

3. (a) FULL NAME

Arthur C Leedle

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced W

8. (b) Name of husband or wife: Amelia P. Leedle

7. Birth date of deceased (mo., day, yr.) Dec 13 - 1882 6. (c) If alive, give age: years

8. AGE: 65 Years 0 Months 0 Days 0 If less than one day: hrs. 0 min.

9. Birthplace: Walworth Wis (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

12. Name: Joseph C Leedle

13. Birthplace: Wis

14. Maiden name: Elizabeth Batchlet

15. Birthplace: Wis

16. Informant: Mrs Madlyn L Witt

Address: Bellair Md

17. Burial (Burial, cremation, or removal) Which? Date thereof: Mar 23/48 (month) (day) (year)

Cemetery or crematory: Green Lake Cemetery

Location: LaPorte Ind

18. Funeral director: Jos J. Foster

Address: Bellair Md

19. 3/19/48 (Date rec'd by registrar) 19. 78 P. Fowwood

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1948 at 19 48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to March 18 1948 and that I last saw him alive on March 18 1948.

Immediate cause of death: Cerebral Thrombosis

Due to:

Due to:

Other conditions: Pernicious Anemia 1 year

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

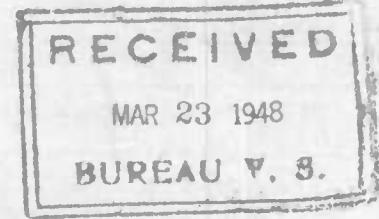
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE: Gerald C Palmer M.D.

M. D. or other: _____ Date signed: 3/19/48
 Address: Bellair Md



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a
02844

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Eric Malm

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mrs. Wm. G. Malm

7. Birth date of deceased (mo., day, yr.)

June 19, 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

49 8 23

hrs.

min.

9. Birthplace

Bridgewater Conn.

(Town, county, and state)

10. Usual occupation

Maintenance, Friendly All.

11. Industry or business

Eric Malm

12. Name

Sweden

13. Birthplace

Sweden

14. Maiden name

Emma Alsen

15. Birthplace

Sweden

16. Informant

Mrs. Wm. G. Malm

Address

605 Ontario, Hanover Place

Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal, White?)

Cemetery or crematory

Mt. Zion

Location

Hanover Place

Pennington & Son

18. Funeral director

Pennington & Son

Address

Hanover Place

Mar. 15 1948

(Date rec'd by registrar)

A. L. Lewis no. 0

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 13 1948 at 2:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, to June 13, 1948,

and that I last saw him alive on Mar 13, 1948.

Immediate cause of death

Chronic Myocarditis

Due to Chronic Stom. Nephritis

Other causes of death

Other

Due to Appendicitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

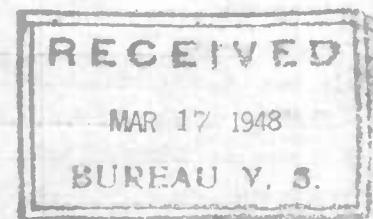
Means of injury Injured at work?

23. SIGNATURE

Charles J. Foley, M.D. or other

Address Hanover Place Mar 13, 1948

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02845

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Harford
 County.....
 City or town.....

(If outside city or town limits, write RURAL and give nearest town) Rural Bel Air

How long in above place of death? 62 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William H. Garrett

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband Bertha C. Snowden

7. Birth date of deceased (mo., day, yr.) April 22 - 1885 6. (c) If alive, give age 54 years

8. AGE: Years 62 Months 11 Days 11 less than one day hrs. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Private families

12. Name Elie Garrett

13. Birthplace Harford Co. Md.

14. Maiden name Sarah Garrett

15. Birthplace Harford Co. Md.

16. Informant Mrs. William H. Garrett

Address Bel Air Md. P. F. S.

17. Burial Burial Date thereof Mar. 17 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Clark Chapel

Location near Darlington

18. Funeral director Mary Tanning & Sons

Address Aberdeen Md

19. 3/15/48 48 00 \$ 1.00
 (Date rec'd by Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Bel Air (If outside city or town limits, write RURAL and give nearest town)

Street No. Shockoe Corner (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 - 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 1947 to Mar 14 1948 and that I last saw him alive on Mar 9 1948

Immediate cause of death: Carcinoma of Stomach ?
Ch. myocardial Disease
 Due to Decompensated, 2400

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

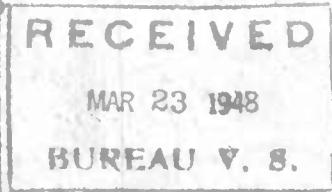
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson, M.D. M. D. or other

Address Forest Hill, Md. Date signed 3/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02846

CERTIFICATE OF DEATH

Reg. Diat. No. 185-

1. PLACE OF DEATH:

County

Harford

City or town

Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

214 Freedom St.

How long in hospital or institution?

3 weeks

3. (a) FULL NAME

Calvin Parson Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Black

Widowed

6. (b) Name of husband or wife

Ella Parson

7. Birth date of deceased (mo., day, yr.)

1870

unk

6. (c) If alive, give age. Donald years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Retired

13. Birthplace

Unknown

14. Maiden name

15. Birthplace

16. Informant Mr. Calvin Parson Jr.
Address 214 Freedom St. Havre de Grace Md.

17. Burial

Date thereof Mar. 15 1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

St. James

Location

Havre de Grace

18. Funeral director

T. Madison Mitchell

Address

Havre de Grace, Md.

19. Date rec'd by registrar

Mar. 15 1948

G. L. Lewis M. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Harford

City or town

Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.

214 Freedom St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

?

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 15 1948, at 5³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9 1948, to Mar. 13 1948

and that I last saw him... alive on

March 9 1948

Immediate cause of death

Angertus Head Fash

DURATION

Due to

Due to arterio Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

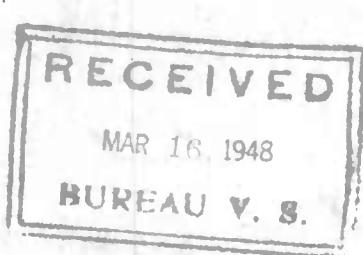
23. SIGNATURE

E. J. Simon

M. D. or other

Address

Havre de Grace Date signed 3-13-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

02847

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH

County Harford
City or town Aberdeen

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Edmond Street Extension

Stay in hospital or Inst. (yrs., or mos., or days)

28 years

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County HarfordCity or town Aberdeen Ward No. 1Street No. Edmond Street Extension (If rural give LOCATION)

3. (a) FULL NAME

Sarah Prigg

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife George Warfield7. Birth date of deceased (mo., day, yr.) March 22, 1870 6. (c) If alive, give age years8. AGE: Years 78 Months 0 Days 1 If less than one day hrs. 0 min.9. Birthplace Perryman, Harford, Md. (Town, county, and state)10. Usual occupation housewife.11. Industry or business None12. Name William Holland13. Birthplace Harford County, Md.14. Maiden name Maria Lewis15. Birthplace Harford County, Md.16. Informant Annie ScottAddress Aberdeen, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 27, 1948 (month) (day) (year)Cemetery or crematory Union M. B.Location Near Aberdeen18. Funeral director Henry Tarrington & SonsAddress Aberdeen, Md.19. Mar 26 1948 (Date rec'd by registrar) Nellie B. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948, at 6 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1948, to March 23 1948, and that I last saw her alive on March 21 1948.Immediate cause of death hypostatic pneumonia DURATION 3 daysDue to Congestive Heart Failure 19 daysDue to Generalized + coronary arteriosclerosis unknownOther conditions left hemiplegia 19 days
following Cerebral hemorrhage (Include pregnancy within 3 months of death)Major findings: None
Of operations: NoneOf autopsy: None
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

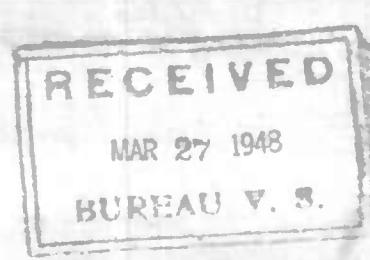
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE Aubrey V. Gould Jr. M.D. M. D. or other 3/23/48Address Havre de Grace, Md. Date signed 3/23/48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. BENSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02848

73

185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

HARFORD

City or town

HAURE de GRACE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 DAYS

Hospital, Institution, or street address where death occurred:

HARFORD MEMORIAL Hospital

How long in hospital or institution?

6 DAYS

3. (a) FULL NAME

Sophie QUENZER

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Decesased.

7. Birth date of deceased (mo., day, yr.)

7-16-1865

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

82

5

25

hrs.

min.

9. Birthplace

(Town, county, and state)

GERMANY

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name

HENRI WETZEL

13. Birthplace

GERMANY

14. Maiden name

Helena WOLF

15. Birthplace

Germany

16. Informant

Elizabeth Shaw

17. Burial

Address 145 Old Dorwart St. Lancaster Pa

Date thereof 3-13-1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Zion Lutheran Cem. Lancaster Co.

Location

Lancaster Penna

18. Funeral director

Fred. F. Goffine

Address

234 W. Orange St. Lancaster Pa

19. Date rec'd by registrar

Mar. 11 1948 G. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND County HARFORD

City or town

Conowingo RURAL

Street No.

ROUTE 222 1 MILE SOUTH RD #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 11, 1948 at 3:30 A.M.

Mar. 5-48 19. to Mar. 11 1948

and that I last saw her alive on March 11, 1948

Immediate cause of death

Primary anemia
Pneumonia

Due to

Due to

Other conditions

Cerebral edema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

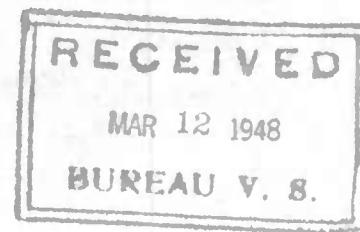
Means of injury

Injured at work?

23. SIGNATURE

John F. Nogueira M.D. or other

Address Hospital of the Poor Date signed 3/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

02849

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County..... *Harford*City or town..... *Rocke*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Robert Francis Rutherford

| | | |
|-----------|------------------|---|
| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
| <i>m.</i> | <i>w</i> | <i>s.</i> |

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Mar 22, 1948

8. AGE: Years Months Days If less than one day

*2 hrs. min.*9. Birthplace..... *Rocke, Harford Co. Md.*

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

| | |
|----------------|------------------------|
| 12. Name | George Clay Rutherford |
| 13. Birthplace | <i>N. C.</i> |

14. Maiden name..... *Hannah Jones*15. Birthplace..... *Harford Co. Md.*16. Informant..... *George F. Rutherford*Address *Rocke, Md.*17. Burial Date thereof..... *Mar 23, 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Centres*Location *Forest Hill, Md.*18. Funeral director..... *Martin G. Furt*Address *Garrisonville, Md.*19. (Date rec'd by registrar) *Mar 23, 1948*(M. D. or other) *Thomas R. Brown*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland*County..... *Harford*City or town..... *Rocke*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 22* 1948 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 22* 1948 to *March 22* 1948and that I last saw him alive on *March 22* 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

*2 hrs.?*Due to *Trauma incident to birth.*

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

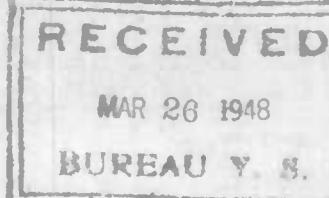
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *Wellard P. Hudson, M.D.* M. D. or otherAddress *Forest Hill, Maryland* Date signed *3/23/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

shown on:

2411 N. Charles St., Baltimore

02850

File No. G 115 APR 14 1948 CERTIFICATE OF DEATH

182

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Harford

City or town..... Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Charles R. Spencer

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

Negro

Single

6.(b) Name of husband or wife:.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1883

8. AGE:

Years

Months

Days

If less than one day

..... hrs. min.

55 64

9. Birthplace..... Maryland

(Town, county, and state)

Laborer

10. Usual occupation:.....

11. Industry or business

MOTHER FATHER

12. Name..... George Spencer

13. Birthplace..... Md.

14. Maiden name..... Mary Ruff

15. Birthplace..... Md.

16. Informant..... Daniel Spencer

Address..... Fallston, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 4/3/48

(month) (day) (year)

Cemetery or crematory..... Tabernacle A. M. E.

Location..... Benson, Maryland.

18. Funeral director.....

Address..... Thos E. Geary

Benson, Md.

19. Date rec'd by registrar..... 3/31/48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Harford

City or town..... Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 31

1948, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 30, 1948, to March 30, 1948

and that I last saw him alive on March 30, 1948

Immediate cause of death.....

Cerebral thrombosis.

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

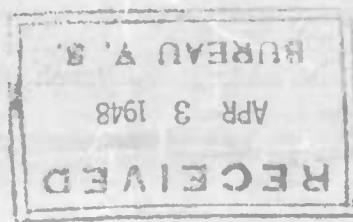
Means of injury.....

Injured at work?

23. SIGNATURE..... Willard P. Hudson

M. D. or other

Address..... Forest Hill, Maryland. Date signed..... 3/31/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02851

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: Harford
 County HAURE de GRACE
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital

Now long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Cecil
 City or town Colora
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Alice Stewart

3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Clarence Stewart

7. Birth date of deceased (mo. day, yr.) January 6 1873 6.(c) If alive, give age 15 years

8. AGE: Years 75 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace Morristown N. Jersey (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER 12. Name John W. Taylor

13. Birthplace Pa.

14. Maiden name Henrietta Flaherty

15. Birthplace Pa.

16. Informant Clarence D. Stewart

Address Colora, Md.

17. Burial Burial Date thereof Mar 22, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Nottingham

Location Colora, Md.

18. Funeral director J. C. Tyson

Address Prising Sun, Md.

19. Mar. 20 1948 G. L. Lazio M. D.
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 48 at 9 55 AM

21. I CERTIFY that death occurred on the date above stated; that attended deceased from March 15 48 to March 18 48 and that I last saw her alive on March 18 48

Immediate cause of death Lobar pneumonia & pleurisy DURATION

Due to

Due to

Other conditions Chronic myocarditis and arteriosclerosis
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

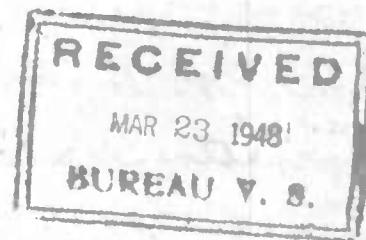
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera MD M. D. or other

Address Hospital - Hand & Face Date signed 3-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a
02852

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

300 Bourbon St.

How long in hospital or institution?

3. (a) FULL NAME

John Franklin Sutor

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Myrtle Edith Sutor

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

64

years

Feb. 12, 1873

8. AGE:

Years

Months

Days

If less than one day

75

1

17

-

hrs.

-

min.

9. Birthplace

Havre de Grace, Md.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

John Sutor

MOTHER FATHER

12. Name

John

Sutor

Md.

13. Birthplace

Md.

14. Maiden name

Rebecca Seal

Perry

16. Informant

Mrs. M. Edith Sutor

Address 300 Bourbon St. - City

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Apr. 1, 1948

(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Havre de Grace

18. Funeral director

R. Madison Mitchell

Address

Havre de Grace, Md.

19. Mar. 31, 1948

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Havre de Grace

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

300 Bourbon St.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 29, 1948, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Mar. 10, 1948, to Mar. 29, 1948

and that I last saw him alive on Mar. 29, 1948

Immediate cause of death

Cerebral Gliosis
Cerebral Hemorrhage

DURATION

Due to

Cardiac Failure.

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

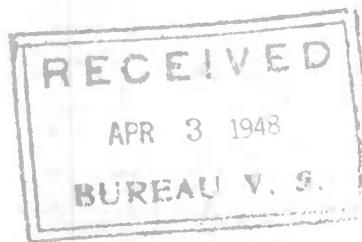
Injured at work?

23. SIGNATURE

Charles J. Foley, M.D.

(or other)

Havre de Grace, Md. Date signed Mar. 31, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

02853

CERTIFICATE OF DEATH

Reg. Dist. No. /TO

M

1. PLACE OF DEATH:

County HARFORD

City or town EDGEWOOD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

—

How long in hospital or institution? —

3. (a) FULL NAME

JAMES EMANUEL WATERS, JR.

4. Sex

M

5. Color or race

W

8. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

NONE

7. Birth date of deceased (mo., day, yr.)

JULY 27, 1944

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

HARFORD Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

JAMES E. WATERS

13. Birthplace

BERLINGTON, N.H.

14. Maiden name

HAZEL LEE

15. Birthplace

WHITEFORD, MD.

16. Informant

JAMES WATERS

Address

EDGEGOOD, MD.

17. BURIAL

Date thereof 3/33/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or mortuary

SLATE RIDGE

Location

YORK Co., PA.

18. Funeral director

Hubert P. Hartman

Address

Delta, Pa.

19. 3/2/

1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County

HARFORD

City or town

EDGEGOOD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

31 ARMSTRONG

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/1 1947 to 3/21 1948

and that I last saw h. M. alive on 1/10/48

Immediate cause of death

INFANTILE PARAPLEGIA &
MENTAL RETARDATION

DURATION

1 1/2 YEARS

Due to

Due to

Other conditions MALNUTRITION

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles W. Stewart Jr. M.D.

M. D. or other

Address 12 YAHDE ST. EDGEGOOD, MD Date signed 3/21/48

